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ABSTRACT

The "clinical ladder" is a grading structure that facilitates career progression and associated differentiation of pay by defining different levels of clinical and professional practice in nursing. The clinical ladder approach, which is well established in the United States, differs from the approach used in the United Kingdom's National Health Service (NHS) clinical grading system in that it is individualized, places greater emphasis on continual development and appraisal, and focuses on the relevant skills and competencies of individual nurses rather than on the posts they are occupying. The feasibility of adopting the clinical ladder approach in the United Kingdom was evaluated through a comprehensive review of available published literature, interviews with managers in three Scottish NHS trusts considering approaches to clinical career structures, and case studies of three health care facilities in England and two in the United States. It was concluded that, in view of the NHS' change in emphasis from central to local pay determination and increasing focus on required skills and competencies, the clinical ladder approach may have direct relevance to health care facilities in the NHS. (Fifteen tables/exhibits are included. A clinical ladders checklist is appended. Contains 99 references.) (MN)

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Recruiting, Retaining and Motivating Nursing Staff: The Use of Clinical Ladders

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1 Introduction

A 'clinical ladder' is a grading structure which facilitates career progression and associated differentiation of pay by defining different levels of clinical and professional practice in nursing. Progression up the clinical career structure is dependent upon the individual nurse meeting defined criteria of clinical excellence, skills and competency, professional expertise and educational attainment.

The clinical ladder system, which is well established in the United States, has been claimed to achieve success in enhancing professional development of nursing staff, improving staff relations, rewarding competency and improving staff motivation. Clinical ladders have also been seen as a way of encouraging the continual updating of professionals skills.

The clinical ladder approach differs from that used in the clinical grading system introduced into the National Health Service in 1987/8 in that it is individualised, places greater emphasis on continual development and appraisal, and focuses on the relevant skills and competencies of the individual nurse, not the post the nurse is occupying.

This paper gives consideration to the clinical ladder approach, by reviewing theory and practice in use, by reporting on some models currently in use in the NHS and elsewhere, and by highlighting some of the organisational implications of using the approach.

The study is based on a comprehensive review of available published literature and other documentation on the subject, interviews with managers in three Scottish NHS trusts considering approaches to clinical career structures, and details

from five case studies using elements of the approach in practice (three in the NHS in England, two in the United States).

The remainder of the paper is in chapters.

Chapter 2

Provides a backdrop of recent developments in skills/competency based pay systems in different sectors.

Chapter 3

Provides a detailed review of publications on clinical ladders in nursing.

Chapter 4

Draws from interviews and case studies to report on clinical ladders and skills/competency based systems in practice.

Chapter 5

Provides an overview of lessons from the literature and case studies, and discusses some of the main organisational implications of the clinical ladder approach.

2 Developments in Skills and Competency Based Pay

2.1 Introduction

This chapter sets the issue of clinical ladders in the broader context of wider developments in competence and skill based pay systems in the non-NHS sectors of the economy. The chapter is in several main sections:

Section 2.2 deals with the definitional issues: what do we mean by skills and competence?

Section 2.3 looks at why employers are interested in developing competency based pay.

Section 2.4 delineates the main types of competency based pay scheme.

Section 2.5 looks at the current use of competency based pay, drawing mainly upon unpublished IES research.

Section 2.6 explores employers' views on the effectiveness of competency based pay.

2.2 Competence

There is considerable debate surrounding the definition of competence or competency. As one observer has noted *'we have the odd situation where a term is in universal use, with any number of different definitions'* (Dukes, 1995). This lack of clarity around the definition and the absence of a theoretical framework can lead to confusion amongst researchers, practitioners and end-users. One difficulty is that the concept is firmly rooted in diverse organisational practice which makes a universal definition difficult to arrive at.

This points to some of the problems in coming to a universal definition of a concept which is so firmly rooted in organisational context. Two broad definitions of competency can be discerned:

2.2.1 Competence as behaviours: competencies

The work of Boyatzis (1982) stresses the behavioural model and defines competency (note the spelling of the term) as: *'an underlying characteristic of an individual which is causally related to effective or superior performance in a job'.*

The emphasis here is on the deep seated traits, behaviours and qualities of individuals that may explain good performance. His work has influenced one of the largest consultancy firms in this area, Hay McBer, which places an emphasis on the behaviours which are associated with 'outstanding performance' when defining a role:

> *'. . . a competency is what outstanding performers do more often, in more situations, with better results, than average performers . . . Competencies as we define them are not lists of all the skills and knowledge thought to be necessary to perform a job. Rather they are those factors which cause people to succeed in jobs.'*

The key point about the behavioural definitions is that they emphasise the behaviours required to produce 'excellent' or 'outstanding' performance. It is not what people have (skills, qualifications, knowledge *etc.*), that explains good performance, it is how they use these competencies that ultimately counts.

One implication of this definition could be that excellent performers are born and not made, in that it is particularly difficult to change underlying personal traits and dispositions. An example of an underlying trait is 'adaptability'. However, it is much easier to train someone to manage their time than to develop the ability to adapt to a changing environment.

2.2.2 Competence as minimum standards

Another definition sees competence (rather than competency) as meeting the minimum standards of a job or occupation. One expert has defined competency as: *'the ability to perform activities within an occupation to a prescribed standard'* (Fletcher 1991).

This working definition is the concept that underlies the NVQ system and the those setting occupational standards for specific groups.

Implicit in this definition is the idea that competencies (defined as skills and knowledge) can be acquired through education, training and experience and are therefore more amenable to change through structured initiatives (such as NVQs or Occupational Standards).

Clearly any definition that organisations care to adopt may have implications for the nature and type of HR systems that they introduce. IES research indicates that employers tend to be pragmatic in their use of the term competency (Hirsh and Strebler, 1995) and that in understanding any one approach the observer needs to understand the specific context of that organisation. This confusion over meaning makes competenc(i)es a difficult area to research.

For the purposes of the following chapter we will be using the terms skills and competencies interchangeably.

2.3 Why the interest in competency based pay?

Competency frameworks are becoming widely deployed across organisations seeking to improve training and development, performance assessment and a range of other HR interventions for different groups of staff. At one level competencies are seen as the 'glue' or, more precisely, the organisational language that can serve to integrate the disparate elements of HRM.

The focus of much organisational (and research) interest in competencies has been in the area of recruitment and selection, career development, performance management and the management of change. Interest in the application of competencies to pay determination is a more recent development. Given the claim that competencies can play an important role in improving performance it is perhaps inevitable that employers should start to explore the possibilities of linking them to pay, and merit pay in particular. This interest in using competencies as a basis for pay decisions has been further reinforced by the problems associated with operating individual based performance related pay (PRP) schemes.

Traditional output based PRP schemes are seen as emphasising short-term results and objectives at the expense of the longer-term skills and development needs of the individual and the organisation. This is reflected in many organisations' current concerns to move away from a 'task based culture' to a culture that values customer service and quality, and is more likely to emphasise processes or networks (Pritchard and Murlis, 1992). It is this new emphasis on skills and behaviours that has encouraged organisations to examine ways and means of developing stronger links between competency and their performance pay systems.

Furthermore, employers have also been looking at how job evaluation systems can be enhanced by including competency measures. In some cases organisations have been adopting competencies as an alternative method for defining the relative worth of jobs.[1]

The IES survey (Strebler and Thompson, 1995) provides evidence on why organisations have adopted competency based pay approaches. Those linking competency to pay ranked the following reasons as important or very important in their decision to implement competencies:

- to support business strategy
- to develop future skills
- to provide competitive advantage, and
- to drive changes in business and structure.

This suggests that these employers may see the introduction of competency based pay as part of a wider business strategy. In this sense, it points to the need to understand the business and strategic context in which the decision to use competency based pay has been reached.

Research into corporate use of performance related pay found that in many cases it was introduced as a 'symbol' of organisational change and transformation (Kessler and Purcell, 1993; Thompson, 1992). Introducing performance related pay was saying something about the organisation they wanted to create,

[1] Thomas Cook, National and Provincial, and First Direct have adopted this approach.

rather than the one they had at that time. The desire to change organisational culture has been particularly strong in the public sector, and performance pay has been explicitly used to make the public sector employees and managers behave more like their private sector counterparts.

2.4 What is competency based pay?

Two broad models of competency based pay systems can be delineated:

1. Competency linked base pay systems
2. Competency linked merit pay schemes.

2.4.1 Competency linked base pay systems

The model underlying this approach is that reward systems should take more account of the individuals who occupy jobs than of the job profile itself (Lawler, 1993). Thus, there is a belief that effective performance in a role is as much to do with the competencies of the individual holding that role, as with the definition of the job requirements. This being the case, there is then a need to develop a means of measuring and assessing individual competency in a 'role'. Thus the idea is to develop general structures in which the individual's levels of competence can be differentiated and rewarded. The emphasis in these types of reward systems is placed more directly on assessments of individuals in jobs rather than the job requirements themselves. In other words it is about paying the person, not the job.

Competency based pay systems that are linked to determining base pay structures generally run alongside formal or proprietary job evaluation systems. Competencies (either generic or specific) can be used to make role descriptions more dynamic and include expected levels of performance and competency that shift with organisational requirements. Competencies are becoming more important in influencing pay structures because they provide an opportunity to reflect business priorities and move away from the more static view of job evalutaiton based pay structures.

Three varieties of competency-based job evaluation systems have been identified (Armstrong and Baron, 1996):

1. point factor competency based job evaluation
2. role classification competency-based job evaluation
3. individually based competency-related role evaluation.

Although slightly different in their operation, all of these approaches share some common features. They use core or generic competencies to inform the headings in the factor plan (*ie* leading team, managing processes, initiative, problem solving). In practice many firms utilising this approach retain their proprietary or self-designed job evaluation scheme for the purposes of ensuring the system is defensible, and providing a link to external market rates of pay.

The risk of gender discrimination associated with traditional job evaluation schemes (Quinn, 1994) is as likely, if not more likely, to be associated with competency linked based pay structures which place more emphasis on individual or group (*ie* male/female) characteristics.

2.4.2 Competency linked merit pay schemes

A second way in which employers are integrating competencies into pay determination is through the appraisal process underpinning merit pay systems. Organisations are adapting the criteria used to make individual assessments in order to incorporate either generic or specific competencies. Instead of either output based measures or wholly subjective assessments, organisations have looked towards competencies as a means of refining their assessment criteria or communicating organisational objectives (*ie* team working, management style, managing change).

Under these systems, employers are modifying the assessment criteria used to determine ratings of individual performance (*ie* Excellent, Good, Poor; 1, 2, 3, 4; A, B, C, D *etc.*). These ratings are then used to determine individual pay progression.

In some of these systems, all of an individual's performance may be assessed using a competency framework (or guide) but in others the competencies may form a part of the overall assessment of individual performance (*ie* a third or a half) and be mixed with output measures (sales achieved, enquiries dealt with *etc.*).

2.5 Current use of competency based pay

This section draws upon a number of surveys of the use of competencies in the UK but concentrates mostly on the IES survey of 380 organisations conducted in 1995. It looks at the following issues:

1. the current organisational uptake of competency based pay systems and their occupational spread
2. employers' views on the use of competency based pay
3. the mechanisms for delivering competency based pay
4. plans for extending the use of competency based pay.

2.5.1 How widespread is competency base pay?

A number of surveys have looked at the use of new pay practices such as competency based pay approaches. The Hay/CBI survey (1996) found that the interest in (if not the actual practice of) linking pay to competency was growing, and that this was skewed towards larger financial and public sector organisations. These findings confirm the earlier IES survey (Strebler and Thompson, 1995). The desire to move towards competency based pay approaches has also been noted by a small scale survey conducted by IRS. Their *Annual Survey of Competency Frameworks* found that whereas 67 of the 124 respondents to the 1993 survey had no intention of linking competency frameworks to pay, by 1995 this had been reversed with 77 out of 123 respondents wishing to make a direct link.

The IES survey (1995) gives more detail on the types of employees covered by such schemes. Table 2.1 (below) gives a breakdown

Table 2.1 Use of competency based pay by occupational group

	%	N =
Manager	82	40
Professional	67	33
Clerical/administrative	49	24
Other non-manual	25	17
Manual	31	15

Base: 49 Organisations

Source: Survey, 1995

of those organisations professing to have competency based pay by the types of employees covered by such pay systems.

Managers and professionals are more likely to be covered by competency based pay than other groups of staff. Over 80 per cent of those using competency based pay operated it for their managers and just over two-thirds included professionals in its coverage. Turning to other groups of staff it can be seen that around one-third of employers extended it to cover manual and non-manual staff.

Returning to the issue of competencies as an integrating mechanism across HR policies, further analysis (not shown here) found that organisations were tending to integrate mainly at the level of the management population. There is a strong theme in HRM thinking which suggests that organisations need to focus their attention primarily on the skills and capabilities of their managers in order to achieve a more strategic 'fit' between the business strategy and HRM policy and practice.

If organisations are linking competency to pay for their managerial and professional staff, what mechanisms are they using to forge this link? The IES survey shows that over 95 per cent of employers with competency based pay use appraisal processes to evaluate competencies for pay purposes. This is much as expected and is possibly also indicative of employers re-focusing their older merit pay systems away from a reliance on targets and objectives towards competency based measures.

2.5.2 Employers' views on competency based pay

The IES survey asked a number of questions about the advantages and disadvantages of linking competency to pay. These dealt with three broad areas:

1. employers' views on the costs of competency based pay
2. employers' views on the fairness of competency based pay
3. employers' views on the impact of competency based pay on other HR policies and practices.

There were three attitude statements on cost. Table 2.2 gives a breakdown of the percentage of respondents 'strongly agreeing' or 'agreeing' with each statement. These dealt with the potential for competencies to lead to more effective control over the

Table 2.2 Employers strongly agreeing/agreeing with statements on costs of competency based pay (per cent)

Attitude Statement	Employers using competencies	CBP Employers
Competencies bring more control over an organisation's paybill growth	14	22
Competencies raise employee expectations of salary increases	51	43
Implementing competency pay is costly	14	21
	(N = 171)	(N = 40)

Source: Survey, 1995

paybill, the costs of implementing competency based pay and finally the extent to which competency based pay could be said to increased expectations amongst employees for a pay rise.

The results show the responses from all employers as well as for those professing to have competency based pay. It can be seen that both sets of employers are most concerned with the possible effects of competency based pay on raising employee expectations for salary increases. In this respect the concerns mirror those normally associated with skills based pay systems.

On the other aspects of cost, both users and non-users of competencies for pay purposes are broadly in agreement. They do not think that implementing competency based pay is too costly, nor are they particularly convinced that it will necessarily bring more control over the organisation's paybill growth. This latter view is likely to be influenced by the concerns over the extent to which competency based pay may raise employee expectations of a salary increase.

Table 2.3 below shows the results for users and non-users of competency based pay for the statements concerning the 'fairness' of such a pay approach. Those with competency based pay schemes are much more positive about this aspect than those without them (who are still broadly positive). Over 70 per cent of those with competency based pay feel that it is a 'fairer way to reward staff', compared to 50 per cent of other users.

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Table 2.3 Employers strongly agreeing/agreeing with statements on the fairness of competency based pay (per cent)

Attitude Statement	Employers using competencies	CBP Employers
Competencies are a fairer way to reward staff	50	70
Competencies should not be used to determine an individual's pay	23	16
Achieved competencies should be matched with reward	58	58
	(N = 174)	(N = 40)

Source: Survey, 1994

2.5.3 Employers' views on the impact of competency based pay on other HR practices

Employers were also asked the extent to which they agreed or disagreed with a number of statements which examined the inter-relationship between competency based pay and other HR policies and practices. It is noticeable from the results that both groups of employer responses are broadly in the same direction, with the strongest message being that *'competencies should be combined with objective setting'*.

This preference for a mixed approach in setting performance criteria for competency based pay may reflect organisations' experiences with merit pay schemes. These have often run into difficulty because employees often see the objectives set by managers as too remote and too difficult to influence or achieve. A further problem is the widespread feeling that the distribution of pay awards are pre-set.

In addition, managers often see them as over-bureaucratic and time-consuming. Blending competencies with objectives in setting performance criteria is seen as one means of creating a common language to talk about performance across the organisation, and a direct link across into training and development processes (Torrington and Blandamer, 1994).

Merit pay schemes are often criticised because they place an undue emphasis on short-term objectives and are often seen as no more than a vehicle to deliver pay. However, competencies may be successful in overcoming some of these problems because

they provide a way of talking about training and development and individual performance using the same language.

Another theme is the importance of resolving pay issues before linking competency to pay. Clearly, employers feel that deep seated problems with current pay systems need to be fully understood and managed before other changes can be made. An underlying issue is the potential for pay to undermine and damage the benefits competency frameworks have delivered in other areas of HRM. Our discussions with employers suggested that many were reluctant to forge the link between competencies and pay because they were fearful that it could backfire, undermining the advantages already gained in areas such as training and development.

2.5.4 The mechanics of competency based pay

The IES survey asked a number of questions about how competency based pay was delivered to employees. In other words, what pay mechanism was used to allocate competency based pay to employees. Three broad choices emerged — a pay matrix, increments, and non-consolidated cash bonuses. A pay matrix is a mechanism that awards salary increases on the basis of both performance assessment and position in the salary scale. Under this approach, those individuals who are rated good performers but are at the bottom of a salary structure will receive much higher percentage rises than those rated good performers at a much higher level on the scale. This approach is designed to recognise the learning curve, and anchors around the mid-point on the salary structure which represents the competent performer in the job.

The increment approach gives individuals similar size increments for ratings of performance — *ie* a good performer might receive three increments whereas an average performer may receive one (or none). The other way competency pay can be paid is as a cash bonus rather than being added into base salary. This has the advantage of giving more paybill flexibility to the employer and reducing long-term paybill costs.

Employers appear to use a mix of approaches — both pay matrices as well as bonuses, or a combination of increments and bonuses. This may reflect the fact that in many organisations employers may be constrained by existing pay systems, or that

different types of linkages operate for different groups of employees.

2.5.5 More competency based pay in the future?

We have considered employers' views on the pros and cons of competency based pay, and examined the context in which these pay approaches have been introduced. The IES survey also asked questions about employers' future use of competencies. It is this question which gives us some idea of the extent to which competencies may become more important for determining pay in the future.

Over 80 per cent of those responding to the question *'will your organisation extend the use of competencies in the future?'* said that they intended to use them more widely. When asked to which areas they were planning to extend their use, the following HR activities emerged as the most important:

Training and development	(20%)
Performance management	(15%)
Recruitment and selection	(12%)
All areas	(11%)

Only three per cent of respondents to the question said that they planned to extend the use of competencies to include pay. However, this figure may be an underestimate, as those saying that they planned to use competencies for 'all areas of HR activity' or those considering a link to 'performance management' may also include pay in their definition. Optimistic estimates would then point to 15 per cent or more of employers in the IES survey actively considering whether to link their use of competencies to pay. The bulk of these are larger private sector employers.[1] However, the picture is still predominantly one of a small number of organisations either using or considering the wider use of competencies for pay purposes.

The survey went on to ask those who were *not* intending to extend their use of competencies, what the reasons were for this

[1] This figure is much lower than that recorded in the Hay/CBI and IRS surveys.

decision. The answers to this question, although not specifically asked in the context of pay, may give us some inclination of the types of factors that may explain employer reluctance in this area.

The most important constraint would appear to be the amount of time involved in developing competency frameworks. Nearly 42 per cent of respondents cited this as important. The next important constraint related to the perceived complexity of competencies. Over 31 per cent of respondents felt that this was an issue and over one-fifth were also unsure about which approach to adopt.

It is worth noting that time and complexity issues far outweighed concerns about cost — only 14 per cent identified this as an important constraint to the further use of competencies.

2.6 Employers' views on the effectiveness of competency based pay

The IES survey (Strebler and Thompson, 1995) asked respondents to assess the extent to which linking pay to competencies had, in practice, made any impact on the organisation or the individual. These views were probed by means of attitude statements. The responses are given in Table 2.4, broken down by those organisations using competencies and those linking them to pay.

Table 2.4 Employers strongly agreeing/agreeing with statements on the impact of competencies (per cent)

Attitude Statement	Employers using competencies	CBP Employers
Competencies have increased profitability	16	24
Competencies have led to improved customer satisfaction	28	36
Competencies have improved employee motivation	61	56
Competencies have reduced paybill costs	3	6
Competencies have helped to transform the culture of the organisation	47	53
	(N = 153)	(N = 34)

Source: Survey, 1994

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Using competencies is seen to confer two main benefits: improving employee motivation and transforming the culture of the organisation. This view is consistent across those who use competencies as well as those who link competencies to pay.

Another way of considering the effectiveness of competencies is to compare the objectives employers want to achieve through introducing competencies, and their views on what had been achieved in practice. In the survey we asked employers why they had introduced competencies in the first place. Among the more important reasons cited was the desire to use competencies to 'facilitate the change of organisational culture'.

It could be argued that there is some evidence that employers using competencies (be they linked to pay or not) have gone some way to realising this objective.

The second perceived impact of competencies has been their ability to improve employee motivation. It may be the case that competency frameworks have motivated employees to improve their skills and competencies in some way, but this can only be successfully addressed through detailed case study.

However, the evidence (albeit limited to a small number of firms) does suggest that employers do perceive real benefits are to be gained from introducing competencies and linking them to pay.

2.7 Summary

This chapter has outlined the key trends and developments in competency based pay. More organisations are using competencies because they believe it helps them achieve certain organisational objectives, namely in creating a new organisational culture and motivating staff. There is still some confusion around the definitions of competency and we argued that these definitions are organisationally specific, and may therefore influence the way in which employers develop links to pay.

The survey evidence points to some variety in the type of scheme being termed competency based but there is also strong evidence to suggest that many organisations are using behavioural based competency measures to refine their individual based merit pay schemes.

The survey evidence also points to a growing interest in forging direct links between competencies and pay, but a dearth of organisations actually putting it into practice, with many concerned that if they have problems in this area it may undermine their hard work in using competency frameworks for training and development.

Although there have been no thorough case study evaluations of competency based pay approaches, the IES survey found that employers thought that many of their business objectives (*ie* changing the culture and motivating employees) had been met by their competency based pay approach. Their one main concern was whether such pay schemes would also open up expectations among staff for higher pay increases and thereby lead to paybill inflation.

This chapter has looked at the broader context of competency and its link to pay in the UK. In the next chapter we concentrate our focus on the issue of clinical ladders in nursing.

3 Clinical Ladders in Nursing A Review of the Literature

3.1 Introduction

This chapter reviews previous publications which have described or examined the use of clinical ladders for qualified nurses. The majority of the literature is from the United States, with other work having been published in Britain, New Zealand and Australia. Unpublished but relevant work from Scandinavia was also identified. This review is in three sections:

- Section 3.2 reports on the theoretical underpinnings of the use of clinical ladders.
- Section 3.3 reports on single and multi-site descriptive literature.
- Section 3.4 reviews literature in which some attempt has been made to evaluate (rather then describe) the use of clinical ladders.

3.2 Clinical ladders: Rationale and definitions

This section reports on the development of definitions of, and rationales for, clinical ladders in nursing.

The theoretical underpinning for the use of clinical ladders, in terms of frequency of citation at least, is primarily drawn from two sources: a paper by Zimmer (1972), and the published work of Benner (*eg* 1982; 1984). The timing of publication of these studies is of relevance. Zimmer argued for the development of a career ladder for clinical nurses in the United States, to improve job satisfaction and staff retention. She drew from various theories of organisational development and individual motivation.

Her paper predates the general introduction of clinical ladders (which were first cited in the literature later in that decade) and

puts forward arguments which were to become familiar in the literature — that clinical ladders, based on structured career progression and professional recognition, would assist in motivating clinical nurses, and contribute to improving staff retention and individual performance.

Outlining a 'rationale for a ladder for clinical advancement', Zimmer described three stages in the development of a staff nurse — entry level, intermediate and advanced practice. The 'ladder' would provide a framework for differentiating between the three levels of performance. Whilst accepting that a ladder for clinical advancement would not in itself achieve the desired objective of 'recognition of excellence in practice via a promotional system', she argued that it was 'one significant and essential means to this result'.

In contrast, the published work of Benner, which focuses on the development of clinical excellence in nursing, post-dates the introduction of clinical ladders to some hospitals in the United States. Benner draws from theories of experiential learning in developing a pathway for clinical advancement for nurses. The career path 'from novice to expert' is delineated on the bases of the attainment of additional skills and competencies. Benner postulated that there was a five stage pathway for clinical nurses — novice, advanced beginner, competent, proficient, and expert, drawing from work previously undertaken on skills acquisition of airline pilots (Dreyfus and Dreyfus, 1980).

Benner's work has proved to be highly influential in providing a theoretical framework for the development of clinical advancement programmes and clinical ladders. Her work is commonly cited in support of the application of clinical ladders for nurses in the United States, and unpublished papers from Australia, New Zealand and elsewhere. It should be noted, however, that the managerial rationale for clinical ladders (retention, improved job satisfaction, improved clinical performance) had been developed, and clinical ladders were already in use, prior to the publication of Benner's work. Benner and clinical ladders have become synonymous. Her work provided a clearer and more detailed theoretical underpinning for their use, and assisted in refining their application in practice, but the use of clinical ladders predates the development of the 'novice to expert' pathway.

3.3 Clinical ladders in practice

The implementation of clinical/career ladders in a nursing practice environment has been the subject of a large number of published articles and papers. Any literature search drawing from US sources published since 1980 will reveal several dozen such papers, mainly adopting an uncritical, descriptive 'here is how we did it' approach. These papers usually describe the introduction of a clinical ladder to a single site, often refer to the work of Zimmer and/or Benner in highlighting the rationales for introduction, and rarely report on any evaluation of the effect of using a ladder.

3.3.1 United States

This section highlights some of the publications which fall under this 'descriptive' heading, drawing from some of the single site reports (more are listed in the bibliography) but focusing mainly on the relatively few publications which have attempted a descriptive overview of introduction *across* a number of sites.

The first descriptive overview of the introduction of clinical ladders was published in the *American Journal of Nursing* (Huey, 1982). This paper reported on the structure and criteria, procedures and incentives for advancement of clinical ladders in a selection of US hospitals. In most cases, hospitals reported that their ladder had been implemented in the mid-1970s; the variation in characteristics between sites was highlighted in the paper. Huey reported on ladders with between three and six 'rungs', and with one to four 'tracks' (some hospitals had developed separate tracks for clinical nurses, nurse educationalists, nurse manager/manager/administrators, and nurse researchers/researchers/nurse practitioners). Table 3.1, abridged from Huey, illustrates the variation in characteristics.

Huey raised the issue of the use of language and descriptors in defining and implementing clinical ladders, pointing out that different hospitals used different language to describe the same elements — and also used the same language to define different elements. For example, in some hospitals 'education' referred to the nurses' participation in continuing education, in others it referred to teaching activities (to other staff, patients or relatives). She also made the distinction between *clinical* ladders, which related solely to competencies within clinical nursing, and *career*

Table 3.1 Levels, salary differentials and competency definitions, 1982

Hospital	No. Levels ('rungs')	Salary differential Entry to Top	Definition of competencies
Mercy Hospital, Des Moines	5	68%	Four nursing process skills: assessment, planning, implementation and evaluation
Mt. Sinai, Florida	4	64%	Four roles: clinical, managerial, education, research
Family Hospital, Milwaukee	4	43%	Four levels of performance defined in four nursing process skills (see above), plus continuing education, committees
Evanston Hospital, Illinois	4	43%	Three categories: clinical practice, co-ordination and management of care professional behaviour
University of Texas Cancer Centre	6	100%	Four nursing process areas (see above)
University of California, San Francisco	5	68%	Five categories: nursing process, teaching, communication, evaluation skills, research
Rush-Presbyterian, Chicago	4	58%	Four roles: clinical practice, administration, education, research

Source: Abridged from Huey, 1982

ladders, which included 'multi-track' approaches encompassing posts for nurses in management, education and research.

Huey concluded by stating that:

> *'most clinical ladders exist simply to reward nurses for clinical behaviour rather than to really match different levels of practice to patient care. In trying to woo nurses in a nurse shortage, hospitals have learned that retention systems are worth the expense when compared to the costs of recruitment and orientation.'* (p.1526)

She questioned whether such an approach would continue in a 'tight' labour market, but suggested that hospitals in which ladders were *negotiated* with staff representation, rather than imposed by management, might be more robust and have greater longevity.

Drawing from the report by Huey, the American Nurses Association (ANA) (1984) published a resource document on clinical ladders: 'designed to serve as a resource for individuals

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who are charged with initiating and implementing career ladder programs' (p.5). The document is explicit in arguing (to the extent that the argument is in the title of the publication) that clinical/career ladders improve recruitment and retention and professional productivity of qualified nurses.

The ANA paper lists over 50 hospitals in the United States which provided information on the implementation of clinical/career ladders, and gives a descriptive overview of development in the US up to the mid-1980s (the main references are to the same hospitals reported by Huey, 1982). Its key conclusions are:

> *'identifying performance criteria that demonstrate role expectations and competencies, in terms of the kinds of knowledge and skill required, for nursing practice at each level within a career pathway may be the most difficult task in designing a career ladder'* (p.15)

and:

> *'because a career ladder for nurses is a relatively new concept in many organisations, evaluation data and information about implementation are limited . . . since most career ladders are recent innovations, little is known about their effectiveness.'* (p.19)

The third in a sequence of US based descriptive overviews was a 'strategy briefing' published by the American Hospitals Association (AHA) in 1991 (Merker *et al.*, 1991). Targeted at a hospital management readership (rather than at nurse managers and clinicians) this paper also promoted the retention/productivity benefits of clinical ladders. Designed as a 'how to do it' report, the paper suggested that there were four 'basic parts' of a clinical ladder:

- create a committee to design/implement
- establish programme goals
- design the structure
- identify criteria for achievement.

The paper also gives details of four hospital level clinical ladder programmes (three in the US, one in Canada) and emphasises the benefits of integrating a peer review process into the criteria for advancement.

Written at the time of the last major nursing shortage in the US, the AHA paper highlights the perceived benefits of clinical/

career ladders in relation to staff retention and job satisfaction but gives no evaluation or analysis.

Some indication of the extent to which the implementation of clinical/career ladders has spread through the US hospital system over the last decade, can be derived from two more recent published overviews. Havens and Mills (1992) surveyed a random sample of 520 US hospitals in 1990, to explore the extent to which various features of professional recognition and compensation (including clinical ladders) were utilised in their hospitals. They found that one-third of the hospitals (34 per cent) reported implementation of clinical ladders by 1990, with a further third planning implementation over the period 1990-1995. The authors noted that:

> *'The greatest rate of change among structural features was in the area of clinical ladders, with a 96 per cent rate of projected increase over 1990 implementation. With approximately one-third of the institutions already using these features in 1990, there seems to be a distinct move toward making these reward structures more available.'* (p.20)

Murray (1993) reported on a survey of 543 hospitals in the United States and over 200,000 registered nurses in 1990/1991. A total of 239 of the hospitals (44 per cent) reported using clinical ladders, with an average reported coverage of 70 per cent of total nursing staff participating. The report by Murray is the largest and most detailed available US national survey on the use of clinical ladders found during this review; combined with the results of the Havens and Mills study, the implication is that by the beginning of this decade approximately one-third or more of surveyed US hospitals reported using clinical ladders.

Murray reported that most hospitals were using a three level (28 per cent of hospitals) or four level (53 per cent of hospitals) career ladder. Average distribution of nurses by level, in hospitals reporting one to six level ladders is shown in Table 3.2. It is evident that distribution tends to 'bunch' at the lower levels.

Other main findings of the survey were:

- Seventy per cent of hospitals reported that entry onto their ladder was by application (30 per cent reported automatic entry).

Table 3.2 Percentage distribution of participants at each level, by numbers of levels

% of Nurses	1	2	3	4	5	6
at level 1	100	78.3	54.5	21.5	25.4	32.4
at level 2	–	21.7	32.2	52.8	44.3	16.8
at level 3	–	–	13.3	19.4	15.3	16.8
at level 4	–	–	–	6.3	7.7	20.0
at level 5	–	–	–	–	7.3	11.8
at level 6	–	–	–	–	–	2.1

Source: Murray, 1993

- Over half (53 per cent) reported advancement was based on committee approval, as against 35 per cent by points rating, and 12 per cent by a combination of the two.
- Sixty two per cent of hospitals report evaluation of individual nurses on an annual basis and 17 per cent reported six monthly evaluation, with the remainder reporting other sequences.
- Base salary increase was the most often reported reward for advancement (79 per cent) with 16 per cent reporting lump-sum reward.
- The main criteria used in determining advancement are listed in Table 3.3. A number of measures of educational attainment, professional experience and leadership skills were the criteria most reported by the hospitals.

Murray summarised her findings by noting a 'resurgence and increased interest in use of clinical ladders', in the US, but with significant variations between the design of specific clinical/ career ladders, in terms of theoretical framework, processes and compensation packages. Whether this 'resurgence' has been maintained through the 1990s with economic recession, cost containment and a reduction in nursing shortages is difficult to ascertain from the literature.

3.3.2 Other countries

Whilst the vast majority of publications relating to clinical/ career ladders in nursing stem from the United States, relevant studies have been published in other countries, notably Australia and New Zealand.

Table 3.3 Criteria used in the clinical career ladders

Criteria	% of hospitals reporting use
Continuing Education Credit	84.1
Committee/Project Participation	83.3
Experience as RN	82.0
Leadership	81.2
Performance Scores	75.7
Professional Certification	75.7
Completed Level of Education	64.9
Experience at Hospital	63.2
Research	48.1
Community Service	41.8
Other	22.6

Source: Murray, 1993

In Australia, the South Australia branch of Royal Australian Nursing Federation (RANF) devised and promoted the implementation of a clinical career structure for nurses in the early 1980s. Drawing explicitly from the US clinical ladder model, and the work of Benner, the career structure which was developed had five levels (novice to expert) and three branches from level III to level V (clinician, management, education) (Silver 1986a, Silver 1986b). Similar developments have occurred in other States in Australia (*eg* Western Australia: Marsh, 1988). Evaluations of the South Australian system were published by Dale (1987) and Koch (1990).

Dale (1987) conducted a pilot study on nursing staff in an oncology ward, over an 18 month period. The study found improvements to patient care (as measured by patient opinion surveys) and quality of care (as measured by the Rush-Medicus Quality Monitoring Tool) but it was not possible to directly attribute these positive changes to the implementation of the new career structure.

A larger study, covering 5,000 nurses in 11 health settings, was conducted in 1986 (Koch, 1990). This trial, covering approximately one-third of the nursing workforce, was evaluated over a six month period using a battery of research instruments

covering job satisfaction, quality of patient care, vacancy, turnover and absence levels, and costs of orientation and recruitment.

The author stresses that the short duration of the trial period places severe limitations on data interpretation, but overall findings were that job satisfaction increased for nurses levels II to V (and reduced for level I); that quality of care increased, as measured by quality audit and by patient satisfaction; vacancies reduced in three units and remained at the same level in the remaining five providing information; and overall absenteeism was reported to have fallen. Variations in calculation methods used by different units prevented a comparison of cost data.

The author reports that the South Australian government was convinced by the results of the evaluation (particularly those relating to quality assurance/productivity) and ratified implementation of the new system throughout the State. Full implementation was achieved by 1988.

Paralleling the situation in Australia, it was the professional nursing organisation in New Zealand which took the lead on promoting the development of a new clinical career structure for nurses. In the 1980s the New Zealand Nurses Association (NZNA) began developing proposals for a clinical career structure which sustains 'a workforce which has sufficient stability to enable recognition, promotion and support of innovative, effective practice'. These proposals were finalised and adopted as policy by the NZNA in 1990.

A five level career structure was proposed, with advancement based on accountability, decision making, contribution to research and development, and planning of clinical practice. The new structure was aimed to 'contribute to the growth of professional knowledge, the retention of skilled nurses in the workforce and the provision of quality care to clients. Potential entrants to the profession can envisage a rewarding career without removing themselves from continued involvement in clinical practice' (NZNA, 1991, p.10). In short, the 'classic' arguments in favour of clinical ladders were being put forward: improved retention (both in nursing and in clinical nursing) professional development and improved quality of care.

The rapid reforms of the New Zealand health service in the 1990s, with the introduction of local pay, autonomous hospitals and an internal market, represents a similar, if more radical

approach to that adopted in Britain. The subsequent implementation of clinical/career ladders for nurses in a number of 'crown health enterprises' (CHE) (New Zealand equivalent of trusts) is therefore of particular relevance to Britain, particularly as the nurse education system and employee relations climate are also similar.

Versions of the original NZNA (now renamed New Zealand Nurses Organisation) career ladder have been used in developing unit level competency based systems in several CHEs in New Zealand. Each individual CHE has been developing its own system, most in collaboration with the NZNO (Jones, 1994).

Short reviews of progress in implementation were published in 1995. A paper by a professional adviser to the NZNO reviewed 14 clinical career pathways (CCP) currently being designed or implemented (Trim, 1995). She highlighted some common features: most made use of Benner's work as a theoretical basis; the approach was always competency based, with an average of five levels for registered nurses and three levels for enrolled nurses; all but one system were being designed by working parties including NZNO representatives. About half of the units had fully implemented the CCP without any pilot or trial phase.

Further details of progress with implementation of CCPs in 12 CHEs were given in August 1995 (O'Connor, 1995). This review highlighted variations between units in terms of design and pace of progress. Some CCPs have not been linked to pay levels during design and implementation; this was a deliberate attempt to separate agreement of principles and features of the CCP from the contentious issue of 'pricing' the new structure.

No published research or evaluation of the introduction of CCPs in New Zealand was identified during this review. This is unsurprising, as most units are currently involved in final design and implementation, rather than management and monitoring of a 'mature' system.

This review has focused on English language publications, and has therefore concentrated on North America and Australasia. There are also reports of clinical ladders being piloted in Scandinavia (SHSTF, 1995), and the use of a competency based clinical career structure in nursing has also been promoted more generally by the International Council of Nurses (ICN, 1995).

The 'opportunities' of developing a clinical career structure identified by ICN (1995) included the following:

- recognition and reward for clinical competencies
- increased job satisfaction in the clinical area
- better adaptation of continuing education programmes along the lines of competency training needs
- turnover rates greatly reduced
- improved standard of care
- peer review introduced
- greater carer mobility and transparency
- nursing roles better defined
- accommodation of organisational goals and nurses' personal goals.

This section has reviewed descriptive studies papers which have reported on the implementation of clinical/career ladders in units in the United States, Australia and New Zealand. Some common threads run through these reports:

- In most cases, the work of Benner and/or Zimmer is referred to as forming a theoretical underpinning.
- The rationales for designing and introducing clinical career ladders normally include improving staff retention, improving quality of care/'productivity'; providing a mechanism for retaining qualified and experienced nurses in the clinical environment; and differentiation between different levels of clinical competency.
- Design and implementation is localised, often based on the work of a steering group of managers and clinical nurses (in unionised workplaces often with the involvement of union representatives, either as working group members or as parties to the negotiation and 'pricing' of the new structure). A state level template has been used in Australia, and a national level structure was proposed, but not implemented in New Zealand.
- In most cases, career ladders are uni-disciplinary, and focus only on first level registered nurses (some in New Zealand are reported to cover other staff groups).
- Three- or four-level ladders appear to be the most common structure, sometimes with separate 'branches' for education and management at advanced levels.

- The specific details of criteria for assessment and progression vary from site to site, but most place a heavy emphasis on participation in continuing education, clinical expertise, communication skills, and participation in research and evaluation. Many structure the assessment according to four domains of practice: clinical, management, communication, and professionalism. Most use an evaluation committee comprised of nurse managers and clinicians, to assess progression; peer review is often emphasised as a major element in the assessment process.

In the next section, the comparatively few reports which include some attempt to evaluate or assess the implementation of clinical/career ladders will be reviewed.

3.4 Evaluation

Few published reports or articles have attempted to evaluate the implementation of clinical/career ladders. This section reports on seven papers and three unpublished PhDs which have undertaken some form of evaluation.

These papers fall into one of two categories: studies which examine aspects of nurses' job satisfaction, and workplace behaviour of nurses employed in a ladder system, and studies which attempt to assess costs and benefits of implementing a clinical/career ladder.

Roedel and Nystrom (1987) evaluated the implementation of a three level clinical ladder in a 200 bed general hospital. The study was conducted eighteen months after implementation, and focused on 81 nurses participating in the clinical ladder. The aim of the study was to assess the extent to which nurses on the advanced levels of the ladder (levels II and III) reported greater job enrichment.

The study used a validated questionnaire (Hackman and Oldham Job Diagnostic Survey) to assess job characteristics. Results reported by nurses on each level were compared; and all results were compared against 'norms' derived from the responses of several thousand other professional staff. Main findings were that nurses on Level III reported greater autonomy, motivation, and 'task identity' (the degree to which a job requires completion of a 'whole' and identifiable piece of work); these nurses also experienced greater job satisfaction.

This study provides some statistically significant evidence that job satisfaction was higher for the small number of nurses on level III in the hospital career ladder. The published study does not give details of criteria for assessment used in the clinical ladder or salary differentials between levels.

Malik (1991) investigated the job satisfaction of nurses in a critical care unit using clinical ladders (n=17; 77 per cent response rate) with those on a unit not using clinical ladders (n=25; 68 per cent response rate). The research instrument used was the Stamps and Piedmonte index of work satisfaction questionnaire.

The study attempted to examine a range of demographic and organisational characteristics in relation to levels of job satisfaction, but small sample size limits the relevance of these comparisons. In relation to job satisfaction and clinical ladders, the study found statistically significant mean higher scores of job satisfaction in the unit using a clinical ladder. The author concluded that 'this analysis could infer that the career ladder contributed to higher job satisfaction' (Malik, 1991, p.120f), but stressed that other differences between the nurses on each unit, and between the organisation of the units themselves, may have explained the differences in the reported level of job satisfaction.

This study, which attempts a cross comparison of nurses in a unit with a clinical ladder, and nurses in a unit without a ladder, is severely limited by the small sample sizes, which restrict the potential for controlling for demographic differences between the nurses, and differences in organisational characteristics. No details of the clinical ladder, in terms of levels, criteria or pay differentiation, was given in the study. (See also Malik, 1992.)

Schultz (1993) undertook a 'comprehensive evaluation' of a four level clinical ladder used in a large university teaching hospital. Quantitative data was acquired using a number of research instruments, including the Stamps and Piedmonte index of work satisfaction. This was supplemented by routinely collected data on costs and staffing. The attitude survey had a response rate of 58 per cent, which included 152 clinically advanced nurses and 203 'non-promoted' staff. Main results were:

- In relation to cost-benefit, the author attempted to assess the benefits accruing to the organisation from reduced staff turnover as a result of the clinical ladder. Turnover rates were markedly lower for clinically advanced staff in a retrospective

examination of data for eight years of operation of the ladder (the author noted that this did not control for length of service; turnover rates normally decrease with length of service). The author calculated average costs associated with turnover of nurses. However, even if the clinical ladder was the sole reason for reduced turnover, the author calculated that the cost of implementing the clinical ladder outweighed the reduction in turnover costs by approximately $440,000 over the eight year period (a year by year breakdown was not given). Whilst the margins of error in this assessment are high, the author concluded that the 'negative cost-benefit ratio is believed to be accurate' (Schultz, 1993, p.15).

- No statistically significant differences were found between the advanced and non-promoted groups in relation to measures of job satisfaction.
- 'Intent to leave' was measured, as another indicator of job satisfaction. Non-promoted respondents were twice as likely to be considering leaving their post as were advanced respondents.
- Qualitative interviews with individual nurses revealed strong positive support for the clinical ladder system from participating nurses and their managers.

The author concludes that the study 'revealed mixed opinions about the value of the system, and demonstrated only partial achievement of intended outcomes. Since only one system was evaluated, possibilities for generalisation are limited' (Schultz, 1993, p.18).

Begle and Johnson (1991) described a formula for determining the cost/benefits of a clinical ladder system. They identified three main cost areas (planning costs, implementation costs and maintenance costs). They argued that these costs should be 'depreciated' over a period of three years to get a more accurate picture of the cost-benefit ratio. The authors also highlighted the difficulty in identifying and measuring the 'benefits' of the clinical ladder. They suggested computing a 'cost per hire' figure (*ie* a replacement cost figure or turnover cost, including orientation, induction *etc.*) and using this as the basis of determining benefits, or the basis of the reduced turnover associated with the introduction of the ladder. The authors illustrated the use of the cost benefit approach with an example of a unit where three year costs were $134,480, whilst projected savings were $240,000 (the clinical ladder introduction was projected to decrease turnover by eight fewer resignations per

year; establishment of 500 nurses; $10,000 per nurse replacement cost). This scenario gave a claimed 'excellent' cost benefit ratio of 1:2.

Strzelecki (1989, unpublished ED.D; abstract only) surveyed 385 registered nurses working in 24 hospitals which used clinical ladders. The aim of the study was to design and test a research instrument for assessing the effectiveness of clinical ladder programmes in acute hospital settings. Abstract details indicate that the 'majority' of nurses responded favourably to five of the seven defined 'essential outcomes' of a clinical ladder:

1. differentiates levels of clinical competency
2. reinforces responsibility and accountability
3. guide for evaluation of clinical performance
4. assures opportunities for professional growth
5. provides for increased levels of autonomy and decision making.

The author also reported that the majority of nurses reported improved job satisfaction through the use of a clinical ladder to recognise clinical practice.

Bruce (1990, unpublished ED.D; abstract only) surveyed 600 staff nurses drawn randomly from the membership lists of the Massachusetts Nurses Association (238 responses, 40 per cent rate). The study was designed to determine which reward strategies (including clinical ladders) improved job satisfaction and retention of professional nurses. The author used the Stamps and Piedmonte Index of work satisfaction as a research instrument. Significant findings included: the component 'professional status' provided most job satisfaction regardless of education or time in the job; nurses who worked in primary nursing settings were more satisfied; nurses who worked in settings with a clinical ladder were more satisfied with their job than nurses who did not (details of the characteristics of these clinical ladders not available in abstract).

Costa (1990, unpublished; abstract only) examined the effect of the implementation of a clinical ladder programme on patient care and the role orientation of nurses. Data was collected at baseline, six, and eleven months, after implementation. A random sample of 114 nurses was included in the study; research instruments included the Minnesota Satisfaction Questionnaire. Data analysis revealed no significant differences in patient

satisfaction after implementation; nurses reportedly placed higher importance on professional values after implementation, but there was no statistically significant change in reported job satisfaction.

Thornhill (1994) surveyed a stratified random sample of 120 participants and 480 non-participants on clinical ladder schemes in five hospitals in Louisiana and Mississippi. The aim of the study was to compare the profiles of the two groups, and assess perceptions of the clinical ladders as a means of job enrichment. The study used a researcher designed and piloted questionnaire. Response rate was 88 per cent for participants and 80 per cent for non-participants.

Thornhill concluded that the study results 'suggested strongly' that demographic variables such as age, education and years in clinical practice did not influence voluntary participation or non-participation in the ladder approach. She also concluded that the voluntary clinical advancement programmes in place at the five hospitals (no details of the programmes were given in the paper) had limited impact on job enrichment, but that the 'participant' sub-group was significantly different in its responses than was the non-participant sub-group.

The extent to which there are any generalisable lessons from these research studies is extremely limited. Some are based on small sample sizes, and most do not give any specific details of the characteristics of the clinical ladder system(s) under research scrutiny. The limited evidence which is available, when the above limitations are acknowledged, is not, in any case without contradiction. Some studies report links between clinical ladders and improved job satisfaction, others do not. The review did not reveal any significant work which had attempted to research links between the use of clinical ladders and patient care or outcome indicators.

Putting these evaluative studies in the context of the survey on UK employers' use of competency based pay discussed in Chapter 2 raises a number of issues. Firstly, the emphasis on cultural change found in the IES work is mostly absent from the reviews conducted in the US and elsewhere. Secondly, there also appears to be less importance attached to recruitment and retention issues. Labour market pressures may exert more influence over managerial objectives in health care organisational settings than in private sector companies in the UK.

Lastly, there does appear to be consistency in the employee based finding in the US evaluative studies on the use of career ladders and the views of the employer respondents in the IES study. Employers perceived competency based pay to be a source of motivation for employees, and in the US several studies found career ladders led to high job satisfaction scores.

The comparative paucity of published research or evaluation of the implementation or use of clinical ladders is not unsurprising. The complexities of research in this area, the need to account for or control many variables, the use of proxy measures (*eg* turnover as a proxy of satisfaction/dissatisfaction) all complicate the process and limit the applicability of the results. What this section has highlighted is that the claims made for the use of clinical ladders, as is the case with any specific reward strategy or career structure, are neither proved nor disproved by reviewing the limited research based evidence.

3.5 Summary

This chapter has reviewed the literature on the use of clinical ladders, and on the evaluation of that use.

Clinical ladders were first implemented in hospitals in the United States in the 1970s; since then, their use has become widespread, most often based on a three or four level system, using clinical performance, education and competency. Units in New Zealand are also adopting a ladder based approach in the aftermath of health sector reform and the introduction of locally determined pay.

The main claimed benefits of using a ladder include improved staff retention, productivity, and job satisfaction. An examination of the few published evaluations of the introduction of clinical ladders found some research evidence to support these claims, in some employing units; other studies found no evidence of these claimed improvements.

4 Case Studies

4.1 Introduction

This chapter provides details of competency based ladders in practice. The chapter draws on information provided by managers in three NHS Trusts in England which have designed competency based systems for nurses, and on discussions with managers in three trusts in Scotland which are reviewing their options on moving down the competency based route. Additional relevant information is also highlighted which was supplied by managers in hospitals using clinical ladders, in the United States and in New Zealand. The chapter is in five sections:

- Section 4.2 discusses rationales for adopting a competency based approach.
- Section 4.3 examines aspects of the design of competency based ladders.
- Section 4.4 discusses characteristics of some of the systems designed or in implementation.
- Section 4.5 examines issues of implementation and coverage.

It must be emphasised that this chapter reports on the views and practice of management in a small number of employing organisations. Competency based clinical ladders is only one approach of many to nurses grading and career structures — whilst some NHS trusts are interested in this approach, others are not.

4.2 Rationales for using competency based ladders

The review of the literature on the use of competency based pay and clinical ladders highlighted a number of reasons why management had adopted this approach. The literature on

clinical ladders, mainly drawn from the United States of America, revealed that the main factors stimulating the use of clinical ladders had been recruitment and retention difficulties; a recognition of the need to provide more scope for pay increases within clinical nursing ('keeping nurses by the bedside') and to improve staff commitment and productivity.

The literature review highlighted that, in recent years, issues of improving performance and establishing criteria for differentiated practice were more likely to be emphasised as key rationales. Staff retention was less likely to be the only issue during the nursing shortages of the mid/late 1980s. The review also demonstrated that there were comparatively few published examples of studies which attempted to evaluate the extent to which ladders, when implemented, had assisted management in achieving these goals.

Discussions with NHS managers conducted during this study revealed a number of core rationales which had led them to consider a competency based approach:

- retention
- 'valuing' nursing practice/improving job satisfaction
- establishing objective criteria for differentiating clinical practice.

These core rationales are discussed below.

The **retention** of key clinical staff remains a priority for managers. This is based partly on the recognition of managers that, whilst external labour market pressures will continue to wax and wane, clinical skills and competencies will continue to be a comparatively costly, and in some cases scarce, item. Replacement costs and turnover of key staff can impact significantly on unit labour costs, productivity and the quality of care provided by any healthcare organisation. Payment systems which offer scope for improved retention of staff will always be attractive to employers, if they have manageable cost implications.

Linked to the issue of retention within the organisation for clinical nurses is the issue of retention by the 'bedside'. The notion that experienced and advanced clinically based nurses should receive rewards which reflected their expertise, and thus be encouraged to remain in clinical nursing rather than seek managerial posts for advancement, was made explicit during

the introduction of clinical grading in Britain in 1987/8. Similar arguments have been put forward in supporting the use of ladders.

Nurse management structures in many organisations have been 'flattened' in subsequent years, in common with a general trend in the NHS and in other health systems, towards fewer layers of management in provider units. Career structures and career opportunities for clinical nurses have changed (Ball *et al.*, 1985); managers interviewed in the study recognised the need to examine methods of sustaining career development within clinical practice.

The need to **value** nurses and nurses' work, and **improve job satisfaction**, was also highlighted by most of the managers contacted during the study. They recognised that, for many clinical nurses, increased patient throughput and higher levels of patient activity were making clinical nursing a more demanding job. Changes in the deployment and role of junior doctors was also impacting on the work of nurses. It was in management's own interest to develop systems which recognised the value of nurses' work, both in terms of the central contribution nurses made to organisational success in delivering patient care, and in terms of the demands made of individual nurses in achieving this goal.

Linked to this notion of valuing staff was the belief that job satisfaction of clinical nurses could be enhanced by establishing a system which explicitly linked pay and career progression to the attainment of advanced clinical skills and expertise, and which reinforced continual professional development. Implicit, in some cases explicit, in this belief amongst some of the British-based managers was the view that NHS clinical grading was too mechanistic and too focused on managerial and resource issues, rather than on clinical excellence.

Objectivity in differentiating levels of clinical practice was a third rationale underlying the consideration of competency based ladders. Management were looking for an approach to differentiating the levels of competency and contribution of clinical nurses which was based on objective measures and criteria which emphasised the attainment of relevant advanced skills and qualifications, and which placed the onus on the individual to maintain a relevant portfolio of skills, competencies and qualifications. This reflected a recognition of the increasingly

complex nature of clinical practice and the related need to foster a culture which encouraged the continuous updating of skills.

It is important to stress that management in British hospitals were rarely considering competency based ladders in isolation from other developments within the organisation, linked to restructuring of the delivery of services, the introduction of elements of locally determined pay for other groups of staff, and issues of skill mix and staff mix in patient care and support services. The organisational changes occurring because of these factors created a stimulus (in some instances a need) to examine new systems for rewarding clinical staff. Similar links between organisational restructuring and the implementation of clinical ladders is evident during the reform of the New Zealand health service (see Chapter 3).

4.3 Design

The review of literature conducted in the previous chapter highlighted the 'home grown' approach usually adopted by US hospitals when designing clinical ladders. The most common approach to designing a ladder for clinical nurses was for the employing organisation (usually a hospital) to establish a committee or working group comprised of nurse representatives of different clinical specialities, and management, to review options and detail an approach. As in many elements of change management, the emphasis is on achieving staff 'ownership' of the new approach. The aim is both to facilitate acceptance, and to improve the likelihood of continued relevance and success of the new system by tailoring it to the particular needs and priorities of the organisation and its staff.

Examples of US practice are shown in boxes 4.1, 4.2 and 4.3. An example from New Zealand is shown in Box 4.4.

Box 4.1 Case 1 — United States: Health system; 300 bed tertiary care centre plus 20 community clinics

The urban based system employs 4,000 staff, including 850 registered nurses. Registered nurses are unionised and are represented by the State Nursing Association. The tertiary care was 'redesigned' in 1995, using 'patient focused care' methods, and operates on shared governance principles, with staff nurses participating in decision making on professional and clinical issues.

A differentiated practice model for remunerating nurses was introduced in 1994, providing salaried benefits (unusual for USA). There are five levels of differentiation: entry level, plus Clinical Nurse 1-4 (based on Benner).

Total salary is based on basic salary (including service based increments), plus additional professional payment, as follows:

Clinical Nurse I	base salary
Clinical Nurse II	base salary + 3%
Clinical Nurse III	base salary + 7%
Clinical Nurse IV	base salary + 10%

In addition there is a payment for 'lifestyle compensation', based on extent of unsocial hours worked.

Criteria used to determine progression are based on a 'portfolio' prepared by the nurse, covering examples of work (case histories, charts *etc.*), a research report, and performance appraisal, including peer review.

Managers in the organisation claim that the introduction of the system has been 'revenue neutral', with additional costs offset by gains in productivity, better quality of care *etc.*

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Box 4.2 Case 2 — United States: University linked tertiary care hospital

The urban based hospital employs 800 registered nurses (3,000 staff in total). Nurses are unionised. The clinical ladder was introduced in 1982, mainly to assist in retaining key staff. The ladder is three level, with each level having approximately 12 to 15 increments (incremental progression is by seniority). Advancement to levels II and III is by application of the individual nurse. Advancement can be applied for twice annually. The nurse completes an application pack for consideration by a committee comprised of staff nurses, nurse managers and human resource managers. Advancement criteria include peer review, continuing education credits and patient charts.

There is a *cash limit* on the number of level II and III nurses (currently about 10 per cent of nurses are on levels II and III). Shift pay and on-call payments are also made.

Clinical Nurse I	base salary, increments, shift pay *etc*
Clinical Nurse II	as above, + 5%
Clinical Nurse III	as Clinical I, + 8%

Box 4.3 Case 3 — United States: Community (general) hospital

Urban sited general hospital, with unionised workforce. Nurses registered by the State Nurses Association.

The Clinical ladder, introduced in 1994, has two advanced levels of practice. All full time and part time nurses are eligible to apply, after six months of service. Application instigated by the nurses can occur at any time during the year and will be considered within four weeks. An annual performance appraisal, by Unit Director, is the foundation of the application process. Re-application can occur at six-monthly intervals.

Registered nurses are hourly paid, on a 15 point scale with progression by length of service. Additional payments are made for unsocial hours worked, on call *etc.*

Salary Scale: Registered Nurses (1995)

Entry	(US $ per hour)	Additional hourly payment
	13.03	RN Level II +0.75
↓	↓	
240 months	20.23	RN Level III +1.25

Box 4.4 Case 4 — New Zealand: Teaching hospital system

As a result of health sector reform and the introduction of local pay determination, a number of units are beginning to implement clinical ladders.

This multi-hospital system employing 2,400 qualified (and unionised) nurses is basing its clinical ladder on that originally developed by the New Zealand Nurses Association. Details provided by hospital management indicate that they are in the process of implementing a 'multiple track' ladder, with separate routes for registered nurses, registered midwives, enrolled nurses and auxiliaries.

The registered nurse ladder ('professional development programme') has four levels. Progression is based 'solely on performance and achievement of specified, agreed criteria'. These criteria include performance review scores, participation in in-service training, certification and (for levels III and IV) demonstrated skills and competency in clinical leadership. The application packet which has to be completed by each nurse includes information on professional expertise, educational activities, case study exemplars and teaching session evaluations.

All nurses are paid on a five step salary scale, with annual incremental progression. The allowance paid, relating to level of practice (ie I to IV) is an additional payment; shift premiums are calculated on the basis of salary scale plus allowance.

Salary for RN (1995)	Additional allowance
NZ $	
36,000	Level IV +2,000
34,000	Level III +1,200
32,300	Level II +600
30,300	
28,300	

A second approach, also evident currently in some NHS trusts, is to attempt to establish a new system that has been primarily designed by external management consultants (consultants may also be involved in the 'home grown' approach detailed above, but in a facilitative and advisory capacity, rather than taking the lead on design). This consultant led approach can take the pressure off busy management and staff, but the end result may be less readily acceptable to staff, and less likely to take account of the specific characteristics of the organisation.

In either approach, the methods used and system that is designed will draw to some extent on previous theory (*eg* in many US and New Zealand examples, the work of Benner) and practice (*eg* published articles, information from pay networks and employers federations, and advice from management consultants). With over two decades of a track record and several hundred working examples, the United States represents the source of most theoretical and practical models. New Zealand, having more recently begun to implement ladders, is another source of working examples, and one which has a number of parallels with the NHS (New Zealand drew heavily on the US for source material).

There are, as yet, few working examples in the NHS, which creates two difficulties. Firstly, there may be an over-reliance on these few examples (if they are known about) to provide source material for consideration, or over-reliance on consultants to interpret or filter the lessons from these examples (or attempt to apply an off-the-shelf proprietary approach). Secondly, there may be over-emphasis on the US situation, whilst cultural and organisational differences may limit the transferability of information from that source (*eg* most clinical ladders used in the US are in non-unionised private sector hospitals; relatively few hospitals in the US are unionised).

Examples of UK based approaches are given in Boxes 4.5, 4.6 and 4.7.

Box 4.5 Competency based pay at a London NHS Trust

Background

This is an Acute Trust with 1,200 staff and a budget of £47m and is located in West London. Over the years it has experienced considerable labour market problems (mainly high turnover but also recruitment difficulties more recently) and part of the rationale for introducing a competency based structure is to put the Trust in a better position to weather the vagaries of the London labour market. Another important factor is Calman, and the Trust believes the new working practices gained though its competency approach will help deal with the problems it will face with the reduction of junior doctor hours. In addition, the Trust is a pilot site under project 2000.

Structure

The principles of the Trust's approach are (according to internal documents) to allow *'each individual to move up their pay band as fast as their required skills are reached'*. The pay structure for nurses has two grades each with three pay points:

	Nurse Clinician	General Nurse
Foundation rate	£17,442	£13,658
Interim rate	£19,752	£14,708
Senior rate	£21,012	£15,759

These rates include relevant London weightings but do not include unsocial hours premia (paid at current rates). The nurse grades form part of a wider proposed grading structure: Clinical Team Leader, Nurse Clinician, General Nurse, Healthcare Worker. A pilot for nursing grades has been running for a year.

Process

Competencies are assessed by a Nurse Clinician and different methods of assessment are used, dependent on what is being assessed (ie observation, written questioning, oral questioning, testimony of others). There are three generic areas of competency: Clinical Practice, Professional and Educational Responsibilities, and Management and Staff Resources. Within each of these 'units' there are Elements of Competency (eg to undertake the assessment, planning, implementation and evaluation of individual care needs) and each element has criteria to describe the expected level of performance.

The assessor signs off the competency standard and progression happens when the appropriate criteria are met.

Box 4.6 East of England Healthcare NHS Trust

This is a fourth wave Community Trust and employs 1,400 people, 59 per cent of whom are in nursing and related occupations. The new pay approach for nursing staff only applies to four per cent of the 860 nursing and related staff, and the move to the new structure is primarily through new appointments.

The key drivers to adopt a new approach are: an HR strategy to simplify the current nine grade structure to become a four grade one; the desire to clear up the confusion caused by clinical grading; and to control paybill costs.

The new system is a pay spine with six levels, each with a core competency framework and a performance assessment mechanism. The competency frameworks have two dimensions: clinical competencies and behavioural competencies.

The competencies were developed by a managerial project group. Nursing staff were not involved and the Trust does not have a recognition agreement. The competency frameworks were heavily influenced by the MCI framework.

There is a six level system in place (one unqualified and five qualified) and each one has six pay points:

Nursing Assistant	£8,570	6 points to	£10,424
Level 1	£10,022	"	£12,190
Level 2	£13,709	"	£16,686
Level 3 Ward Manager	£15,429	"	£18,768
Level 4 Clinical Expert	£19,519	"	£23,752
Level 5 Grade H, Experts	£21,968	"	£26,737

All appointments to the structure are at the third point on the scale (*ie* the 'standard point') but there is potential to bring less qualified staff at points below this. The standard point is in practice the maximum unless a case can be made for using the top three points. These might be used if an individual with rare skills is recruited or the labour market is tight for certain grades of staff.

The performance management process is still being developed.

Box 4.7 Southern England General Hospital NHS Trust

The interest in competency based pay in this Trust has been assisted by funding from NHSTD to look at local pay. The Trust wanted to get more flexibility across the main Directorates and escape many of the barriers reinforced by the clinical grading exercise. Their work has identified four major nurse roles: Ward Sister, Senior Staff Nurse, Junior Staff Nurse and Preceptorship.

It is an Acute Trust with 1,308 nursing staff (455 of whom are at the top of their respective Whitley scales).

The process of developing the new roles and structures is fully involving staff groups and unions. The unions have given the go-ahead for piloting of new roles (*ie* Senior Nurse). The competencies were developed with staff, supported by a firm of management consultants.

The competencies being developed are behavioural (*ie* teamworking, planning and organising) and are set within the broader framework of Patient Centred Care. The Trust is developing this approach and has its own '[Trust] Approach' based on the US 'Planetree Approach'.

The proposed pay structure will have three spines within a total range of 50 points (£13,500 to £27,000). The incremental steps on the spine are valued at 1.5 per cent and an individual can receive a maximum of three increments in any one year.

More work is being undertaken to develop and refine competencies in different Directorates. The assessment process and mechanisms are still being designed.

One of the key challenges for any management considering implementing a competency based ladder will be to balance the need to achieve staff ownership with the need to meet other organisational priorities and pressures. Designing a system 'in house' will take a longer time period than attempting to apply an off-the-shelf model. Managers interviewed during this study recognised that achieving a successful 'in house' design would take at minimum eighteen months, and in most cases longer. It would also require freeing up of management and staff time to participate in the working group design committee. These managers also emphasised that they believed this time and effort would be worthwhile, leading to a tailor-made system which was more representative of the needs of staff and the organisation.

In the US and New Zealand, the role in the design phase of relevant professions' nursing trade unions, where they are recognised, has tended to be two-fold. Firstly, they have been involved in negotiating an 'enabling' clause or specification in the Union/Management contract, or agreeing to the go-ahead, in principle, for design. Secondly, their representatives, both organisation based and local, have often been involved as part of the working group. In New Zealand, the nursing union monitors the implementation of ladders, and has run national workshops to share local experiences.

The fact that competency based ladders vary in the detail of approach, whilst sharing some common characteristics means that nurses' organisations in these countries have not attempted to be prescriptive about a particular approach. They tend to emphasise the need to adhere to certain principles (*eg* involvement of union representatives in design, objectiveness of criteria, emphasis on professional and clinical aspects, existence of an appeals mechanism) and then work to attempt to ensure these principles are reflected in the local design.

4.4 Characteristics

Whilst there are certain 'unique' elements to any competency based ladders, reflecting local needs and priorities, there are also a number of core characteristics:

- number of rungs/levels
- pay differentials between levels

- skills/competencies/qualification based criteria for advancement
- review process for advancement.

The competency based ladders will have a number of clearly delineated 'rungs' or levels, each representing a different defined level of clinical proficiency/competency. 'Benner' based ladders tend to have four or five levels, reflecting her 'novice to expert' typology, but different US hospitals are reported to be using as few as two, and as many as six levels. Some recent reviews of US systems (*eg* Goodloe *et al.*, 1996) suggest the use of fewer, more distinctly differentiated levels, and it appears that the approaches being considered or implemented in the NHS examples tend to have two or three levels (in some there is a bottom rung or level for healthcare assistants).

Pay differentials between levels vary markedly in different systems. In some US based approaches, additional payments for advancement are non-recurring bonuses, but in other US hospitals, and most reported NHS examples, the approach is based on a different established pay rate or pay range for each level. Pay differentials between levels, in this approach, vary, but are generally five to ten per cent between each level (one manager interviewed in the study suggested seven per cent was the minimum differential which could be considered a 'promotion').

Criteria for advancement normally emphasise aspects of the individual nurse's clinical expertise, professional activities, educational attainments and contribution to research. The most common approach is to establish a predetermined set of competency based criteria, which are then used to judge each application on its own merits. This 'application' normally takes the form of a portfolio of relevant information and evidence prepared by the individual nurse, often supplemented by the results of performance appraisal or evaluation (and, in some cases, by self appraisal and peer appraisal).

The success of an application depends either on scoring a certain number of points, if the system is points based, or conforming to predetermined levels of skills attainment or behaviour, where the system is based on levels of attainment.

The decision on the advancement of the individual nurse is normally made either by some type of review committee or by

management. In some US hospitals this committee is comprised only of staff nurses, but the more usual composition is to have a mix of management representatives, staff nurses and clinical nurse specialists. Review may occur on an annual basis, or more frequently in some hospitals. Some form of quota (direct or indirect) normally applies to limit the proportion of nurses on advanced levels. This can be one or more of the following:

- a cash limit (in one US State, for example, the State Nurses Association has negotiated that money equivalent to one per cent of the nursing paybill will be available in each hospital to fund ladder advancement)
- a predetermined level 'mix', which requires a vacancy before an applicant can apply for advancement
- 'rationing' by making the advancement criteria extremely difficult to meet at the highest levels
- where budgets are decentralised, by giving the budget holding line manager the right to refuse an application (the potential for this to act as a disincentive was emphasised by one manager).

In some cases, advancement and associated pay increase is consolidated, in others there is a requirement for annual review or reapplication from nurses in advanced levels.

The clinical ladder approach co-exists in some hospitals in the United States with other elements of the pay package: incremental progression, cost of living updates, unsocial hours payments *etc*. Some of the NHS trusts which are comparatively advanced in implementation of competency based ladders report that 'buying out' of some of these pay elements (particularly unsocial hours payments) is under active consideration (this development is not restricted to trusts considering the competency route), but other trusts are looking to implement a ladder approach which retains unsocial hours payments and other pay supplements.

4.5 Implementation and coverage

Clinical ladders have been in use in some US hospitals for nearly two decades. Many of the published articles on the US experience indicate that individual hospitals have altered or redesigned their ladder to accommodate changing priorities and requirements over this time period. Hospitals in the US contacted

during this study reported that the committee responsible for review of individual applications was also normally responsible for assessing the need for any changes in approach and for leading any redesign. This need could occur for external reasons (*eg* labour market changes, changes in pay rates at competing hospitals) or for internal reasons (*eg* organisational restructuring).

In the US, coverage of ladders is normally restricted only to registered nurses (RN) — in some cases only to RNs working full time, or near full time. There are also a small number of US published articles referring to the use of the ladder approach for other health professionals (licensed practice nurses, pharmacists and physiotherapists) but the use of ladders is primarily limited to coverage of first level qualified nurses. This reflects the profession specific rationales for use and source of design information, and the fact that RNs are represented by a separate trade union.

In contrast, published articles from New Zealand indicate that some hospitals are running 'parallel' or 'linked' ladders for registered nurses, enrolled nurses and care assistants. This approach to cover the whole 'nursing' workforce is also being examined by some NHS trusts (and is also reflected in the NHS clinical grading structure).

The issue of 'narrow' or 'broad' coverage of staff groups is further complicated in NHS hospitals which may have to consider operating a 'new' ladder based approach alongside the traditional grading structure, if some nursing staff retain their right to payment under the existing national terms and conditions. In New Zealand, pay determination in the health service was rapidly decentralised, creating an immediate requirement for the introduction of local systems; in the NHS the longer lead in time provides management with more opportunity to design and pilot any approach, but also presents management with the challenge of designing an approach which is sufficiently attractive to staff to wean them off Whitley terms and conditions.

It was noted in the review chapters that there were comparatively few published articles reporting on the local evaluation of clinical ladders. Those papers which had been published (with one exception, from the US) took one of two approaches. One approach was to attempt a rudimentary cost-benefit analysis, comparing costs of implementation and maintenance of the ladder (including any increased paybill costs) against any benefits

accrued, measured in monetary terms (reduced cost of staff turnover).

The second method took the 'basket of indicators' approach, looking at changes or trends in routinely collected data (staff absence, turnover, patient satisfaction *etc.*) at and beyond implementation. A small number of academically oriented papers also reported on studies of job satisfaction of staff.

Variations on this second model were reported by managers in US hospitals contacted during the study, but it should be stressed that the data used were being collected for other organisational purposes, not exclusively to monitor the impact or effect of the ladder. Managers in some NHS hospitals also reported plans to monitor the effect of the introduction of competency based ladders.

Much of the interest in monitoring such approaches in NHS trusts has come from Trust Boards who are keen to ensure that the new pay system produces cost savings in paybill terms. In one case this had created tension between the HR Director and the Board because cost savings were promised after three years, whereas Trust Boards are managing budgets on an annual cycle.

The severe cost control pressures which currently exist at Trust level may make it difficult for some Trusts to adapt career ladder approaches where the 'pay-off' is some years down the line. The risk is that they may then opt for more explicit cost control pay models (*ie* quota based merit pay systems) which do not really address the needed changes in Nursing roles.

However, for the other Trusts we visited, the main approach to monitoring effectiveness (outwith cost control) was to assess whether recruitment and retention had improved. Many Trusts (particularly those in large urban areas) are anticipating considerable labour market pressures in the next few years because of the shortfall in nurse trainees, and see career ladders as a key way to retain staff.

Overall, our impression was that Trusts were at the early stages of planning and implementing competency based approaches, and few had given due attention to the criteria they would use for assessing the effectiveness of the models chosen.

4.6 Summary

This chapter has reported on the practical elements of the use of clinical ladders, drawing on information from trusts in the NHS and from the United States and New Zealand. The main issues discussed in the chapter were:

i. The main rationales for implementing competency based ladders were reported to be to assist retention of nurses, to 'value' nursing practice and improve staff job satisfaction, and to establish objective criteria for differentiating clinical practice.

ii. The design of a competency based ladder was normally undertaken by an in-house working group of nurses and managers, usually drawing on previous examples and reference material. In some cases external management consultants were used.

iii. The main common characteristics of competency based ladders were:

   a) the creation of a number of rungs or levels (as few as two, and as many as six were reported in the clinical areas, with separate structures in some cases for managers/ educators)

   b) the establishment of clear pay differentials between the levels (either in terms of different pay rates/ranges or different pay supplements)

   c) the development of skills/competencies and qualification based criteria (normally covering professional practice, education, and research) to determine advancement of individual nurses on the ladder; and

   d) the use of a review committee of nurses to determine advancement, meeting annually or more frequently. The committee would consider the application of individuals, and take account of peer review and management evaluation reports.

iv. Coverage in the US normally covered all registered nurses in an employing organisation. Some New Zealand hospitals were exploring the use of a parallel or limited ladder, covering all nursing staff (including assistants). Some NHS hospitals were also considering this broad coverage.

5 Summary and Conclusions

This report has reviewed developments in the use of competency base clinical ladders for nursing staff. It is evident that competency based approaches to reward strategy are becoming more widespread in a number of sectors, and that the clinical ladder approach for nurses is being implemented in a number of countries, particularly New Zealand and the United States. In the US in particular, the use of clinical ladders is well established, with two decades of use and several hundred local 'models' in operation.

In the context of current developments in the NHS, it is apparent that the current change in emphasis from central to local pay determination, and the greater focus on required skills and competencies, creates a situation in which variants of the clinical ladder approach may have a direct relevance. It is apparent that some NHS trusts are already exploring or piloting the use of such variants.

This review, which draws from other sectors and other countries, serves to highlight some of the potential organisational costs and benefits of going down the clinical ladder/competency pay route. These are listed in Table 5.1 and detailed below:

The main potential benefits of using clinical ladders relate to their emphasis on developing a purpose-built local system which places a focus on professional development, continuing education, and the link between pay/grading and required skills and competencies.

Where staff are involved in the design and implementation of the system there is also the scope for establishing joint 'ownership' of the clinical ladder, by ensuring that it has been

Table 5.1 Potential benefits and costs of using clinical ladders

Benefits	Costs
Focus on professional development	Design costs
Emphasis on continuing education	Administratively complex to maintain
Local 'ownership'	Possible pay drift, if no 'quota' (and if quota, possible disincentives)
Emphasis on team work, where peer review used	Focus on individual application may require change in organisational culture
Establishing link of pay/grading to appropriate skills/competencies	Inter-organisational career recognition and development
Intra-organisational career recognition and development	

Source: IES Survey, 1995

developed in a way which reflects the needs of staff in the organisation.

If the development of the ladder is also linked to the use of peer review as part of the appraisal process, there can also be the additional benefit of supporting a team ethos, and highlighting the inter-dependency of individual professional nurses in the workplace.

Two of the main claimed benefits of the use of clinical ladders (increased motivation, and improved retention of nursing staff) are difficult to 'prove', given the paucity of independent evaluation and evidence. It is clear that many employing organisations in the US are convinced that these benefits accrue, but little published independent evidence exists to back up this conviction.

One final benefit of developing a 'purpose-built' clinical ladder is that it can facilitate and support appropriate career development and progression within the organisation, using professional criteria and competencies which have specific relevance to organisational and employee development objectives.

Some of the main potential costs of using a clinical ladder relate to the direct and indirect costs incurred in the process of developing and maintaining a new system of pay and grading. Implementing any new system will have implementation and transition costs; what is apparent in the use of the clinical

ladder/competency approach is that there is also an ongoing requirement to review and appraise the work and competencies of individual nurses. This requirement represents a continuing time commitment for management and staff involved in the review process. For some of the complex application procedures used by some US hospitals, this can represent a significant potential opportunity cost.

Another issue with potential 'costs' (both monetary and in terms of disincentives to staff) is the need to use some form of 'quota' or cash limit on staff progression up the ladder. The case studies indicated that some organisations use cash limits or numerical quotas to restrict the number of advancements that can occur in any one financial year; other organisations report that they ensure criteria for advancement at the 'top end' of the ladder are sufficiently difficult to limit advancement.

Whilst there is a need for organisations to contain and plan for the financial costs of advancement, there is also a requirement to ensure that the expectations for advancement from individual staff are not frustrated. Clinical ladders are no different from any other payment system in this respect, but decisions have to be made by the organisation on the means to be used to meet the costs of the system, and to support career advancement with its associated financial implications.

In the context of the NHS, another challenge for management considering the use of clinical ladders will be the culture change associated with introduction. The focus on the individual nurse, and on making the case for advancement through individual application is not one that has traditionally been the norm in the NHS, where national grading and incremental progression has been the model. However, the introduction of clinical grading did represent some 'individualisation' (if of post, rather than nurse) and the subsequent moves towards local pay determination have also introduced a broader range of career/grading options. It is also apparent that trade unions in both the US and New Zealand have tended to adopt a pragmatic and constructive approach to the use of ladders, working with managers to attempt to secure compliance to certain principles in the use of ladders.

One final potential 'cost' is unlikely to be a priority for an employing organisation, but may represent a problem for individual nurses, and for the profession as a whole. To the

extent that different employers develop their own 'purpose-built' local pay/grading systems, there will be inevitable implications for career mobility. NHS nurses have become familiar, over the last five decades, with a 'standard' national template for pay and grading, with a common currency and common language and definitions. The use of ladders, or any other 'purpose-built' payment system will represent a move towards a situation where 'like for like' inter-organisation job mobility is no longer the norm, and where there is greater emphasis on the portfolio of skills, qualifications and competencies that the individual nurse possesses. This development is not necessarily a 'cost'. In fact, in the long term, it may be a benefit to the profession and to the delivery of patient care, but there are clearly transition costs, in terms of changing attitudes, processes and practices.

The development of a clinical ladder is only one of a number of options which NHS employers may be considering. Others include single or multi-occupation job evaluation, individual or group merit or performance pay, 'single pay spines' *etc.* In deciding if the use of a ladder is a realistic option, employers will have to weigh up the costs and benefits, and will also have to consider the checklist set out in Appendix 1.

Appendix: Clinical Ladders Checklist

1. Rationales for use

- What are the factors leading to actual/proposed introduction? (Check recruitment/retention; salary differentiation; improve career structure; motivation/job satisfaction.)
- Who will take lead on introduction?
- What sources of advice/information are to be used in deciding on relevance?

2. Design

- Who is responsible for 'design'?
- What sources can be used/consulted?
- What are the options to be considered?
- What are the main proposed characteristics of initial design; can they change as a result of consultation?
- What is to be role of unions and professional organisations during the design phase and beyond?

3. Characteristics of system

- How many 'rungs'/levels?
- What are pay differentials between levels? (Note: this may be dealt with separately.)
- What criteria are to be used for advancement? (Skills/qualifications/competencies.) Who decides?
- What weights given to different factors/criteria?
- Who decides on advancement (is it automatic/peers/management?)

- Is a quota applied/cash limited?
- How often can advancement be applied for?
- Is advancement consolidated, or reapply (if so, annual, biannual?)
- Check on other payments, *eg* unsocial hours, proficiency payments, payments for additional qualifications.

4. Implementation

- What is status? Planning stage/pilot/partial implementation/fully implemented?)
- Timescale of implementation/when implemented.
- If pilot/partial implementation, how selected? Will parallel systems be running?
- What factors are to be used to assess success of implementation, or monitor running of implemented systems?
- More generally, what will be the critical success factors?

5. Coverage

- Who is to be covered by the new system? All nurses/some units/some specialities/'volunteers'/certain grades? Other staff groups?
- What is planned/expected pattern of distribution of staff on different levels? (When new pay rates known, what will be the one-off transitional cost, and annual recurring cost?)

6. Other pay issues

- What are links, if any, with other grading/job evaluation?
- Performance pay/merit pay links?

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